Section 3 - Demonstration Design

Rationale for Waiver

Congress enacted Title XXI, the State Children's Health Insurance Program (S-CHIP), with the express purpose of "providing states with the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low income, children."[1] The State of Minnesota has a long history of commitment, through public involvement, market reform, and state-subsidized programs, to reducing the rate of uninsurance in Minnesota, especially among children. President Clinton himself acknowledged that "Minnesota has shown exceptional leadership in implementing policies that ensure low-income children have access to meaningful, affordable health care," and that the MinnesotaCare Program was used as a model in designing S-CHIP.[2]

Through Medicaid Program expansions in the late 1980's and the Children's Health Plan, established in 1987 and renamed the MinnesotaCare Program in 1992, and through the health care reforms that began in the early 1990's, Minnesota has effectively reduced the rate of uninsurance, assisted many families on AFDC and TANF in moving into the work force, and has provided an option for people without reasonable means to obtain health care for their children. From 1990 to 1999, the rate of uninsurance among children under age 18 decreased significantly from 5.3 percent to 3.4 percent. During the same period, the national rate was rising.

In July 1995, the Health Care Financing Administration (HCFA) greatly enhanced Minnesota's efforts by granting approval of the MinnesotaCare Health Care Reform Waiver, which provided federal Medicaid funds for expenditures on behalf of pregnant women and children enrolled in MinnesotaCare. Due in part to the federal contribution, Minnesota has been able to improve the MinnesotaCare Program by increasing income standards and by expanding the benefit package. We know that MinnesotaCare has not had a negative impact on the rate of insurance--there has been no measurable "crowd-out" effect despite the high income standards in this program.[3]

Title XXI was designed to assist states to reduce the rate of uninsurance among lower-income children, but the funding is primarily available for states that provide coverage for children at income levels above their current income standards. Raising the income standard above the existing level--275% of poverty--is not the best solution to addressing the needs of uninsured children in this State. We have 48,000 uninsured children under age 19 in this State, approximately two-thirds of whom are in families with income below 200% of federal poverty. Many of them are eligible but not enrolled in the existing programs. Our focus in Minnesota

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[1] ***State Children's Health Insurance Program (S-CHIP) Implementation Guide,*** Chairman Tom Bliley, House Committee on Commerce, November 1997.

[2] Letter of December 6, 1999 from President Clinton to Governor Ventura.

[3] Call, K.T., ***et al.***, "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," ***Journal of the American Medical Association,*** October 8, 1997, Vol. 278, No. 14.

must be on reaching those remaining low-income uninsured children.

In addition, there are other needs that should be addressed. We know that racial and ethnic minorities in Minnesota have higher rates of uninsurance, in particular Hispanic people. We also know that American Indians experience higher rates of uninsurance. While we have been successful at reducing chronic uninsurance in Minnesota, we know we have been less successful at reducing the number of people who frequently move on and off of insurance.

Project Proposal

We acknowledge that Congress intended S-CHIP funding to be used to expand enrollment for uninsured children. Minnesota intends to maintain its existing efforts in providing health care to children. But at the same time, Congress created allotments to individual states that were intended to address unmet needs of states. These allotments were already weighted downward for states like Minnesota with lower rates of uninsurance. Minnesota should not be expected to expand coverage and address the unmet need without the use of the S-CHIP funds. We therefore propose the following expansions to our programs, that are targeted toward the real unmet need in this State, without requesting the refinancing of MinnesotaCare under S-CHIP, as we did in our first waiver request. We also propose to include MinnesotaCare enrollees who are parents or caretakers of children.

Enrollment in MinnesotaCare. Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

Presumptive Eligibility. We propose to introduce the use of presumptive eligibility for all children under age 19 who apply for either MA or MinnesotaCare. The expenditures related to the additional eligibility months will be matched at the S-CHIP rate and will count against the allotment.

Premiums in MinnesotaCare. We propose to revise the existing premium schedule in MinnesotaCare so that premiums for children do not exceed the Title XXI maxima. This involves eliminating all premiums for children in families with income below 150% of federal poverty, capping the premium at 5% of family income for families with children, and eliminating the premium requirement for American Indian children. Since these changes require enactment by the Minnesota Legislature, these changes would not be effective until October, 2001. Conforming the premium structure to S-CHIP will enable the State to coordinate any future child health assistance expansions with MinnesotaCare. The net cost of this adjustment would be considered a special health initiative. We request matching funds at the S-CHIP rate for the costs related to eliminating the premium below 150% of poverty, and capping the premium at 5% of family income. We request federal matching funds at 100% of

cost for expenditures related to eliminating premiums for American Indian children, since federal government has a trust responsibility for Indian people, and this trust responsibility extends to the provision of health care.

Coverage of MinnesotaCare Parents. We propose to cover parents an other relative caretakers enrolled in MinnesotaCare with income above 100% but not greater than 275% of the federal Doverty levels by family size. We request enhanced federal matching: funds to cover these Darents under the existing: eligibility criteria. benefit packages and cost-sharing arrangements of the MinnesotaCare Promam.

Other Special Health Initiatives.

- Use unspent Title XXI funds to target child health needs through existing state and local projects that meet Public Health Improvement Goals. The State will contribute to, or fund special health initiatives for children and adolescents in the areas of mental health, oral health and childhood lead poisoning.

- Develop new special health initiatives that meet other Public Health Improvement Goals for children and adolescents, including but not limited to, assuring access to quality health services for children in racial and ethnic minority groups, eliminating disparities in health outcomes for children and adolescents in racial and ethnic minority groups; and promoting health for all children and adolescents.

Demonstration Detail

Upon HCFA approval, Minnesota will seek legislative authority for presumptive eligibility and adjustments to the MinnesotaCare premium schedule as special health initiatives. Those two changes would become effective October 1, 2001. We would claim S-CHIP match for enrollment in MinnesotaCare over the baseline, and for existing special health initiatives described in this proposal beginning with expenditures made in October, 1998. Also, upon HCFA approval, we would begin development of new special health initiatives, through a process that involves a steering committee of state agency leadership, and input from consumers, advocates, providers, other stakeholders, and the Minnesota Legislatures. All federal revenue earned under this waiver would be dedicated to meeting new state costs related to special health initiatives, including the enrollment expansions.

Enrollment in MinnesotaCare. Use of S-CHIP funds to pay for increased enrollment fulfills the basic premise of Title XXI to expand health care coverage of children. Expenditures related to the number of children enrolled in MinnesotaCare above baseline enrollment will be matched at the S-CHIP rate, and will count against the S-CHIP allotment. The baseline is defined as the number of children under age 19 enrolled in MinnesotaCare in September, 1998, which is the month in which our S-CHIP state plan became effective.

Federal matching funds will be calculated by multiplying the average cost per child in MinnesotaCare by the number of child enrollees above the baseline each month, beginning with the month of October 1998. Enrollment related to presumptive eligibility will be excluded from this calculation.

This proposal requires waivers of the definition of targeted low-income children and the limitation on funding for alternative expenditures.

Presumptive Eligibility for Children. The Balanced Budget Act of 1997 gave states the option of conducting presumptive eligibility for children applying for Medicaid. It authorized states to approve health care eligibility determined on the basis of preliminary information by Medical Assistance providers, and entities that determine eligibility for other child benefits such as Headstart and WIC. Health coverage is provided until a final eligibility determination is made if an application is filed within two months.

Presumptive eligibility is a strategy for reaching the low-income uninsured who are eligible but not enrolled in MinnesotaCare or MA. We propose to introduce presumptive eligibility under Section 1920A for all children under age 19 in both MA and MinnesotaCare. We would develop a screening tool, and a process whereby eligible entities would be trained, and screened in order to qualify to conduct presumptive determinations. Expenditures related to the additional eligibility months would be matched at the S-CHIP rate, and count against the S-CHIP allotment. Since this change would require legislative enactment, we propose an effective date of October 1, 2001. For purposes of federal matching funds, State expenditures would be actual expenditures for the presumptive eligibility months.

This proposal requires waivers of XXI requirements, to enable the State to claim the enhanced S-CHIP match for children during the presumptive period, to allow S-CHIP matching funds for the additional eligibility months in these two Medicaid programs.

Premiums in MinnesotaCare. We propose to revise the existing premium schedule in MinnesotaCare so that premiums for children do not exceed the Title XXI maxima. This involves eliminating all premiums for children in families with income below 150% of federal poverty, capping the premium at 5% of income for families with children, and eliminating the premium requirement for American Indian children. Since these changes require enactment by the Minnesota Legislature, these changes would not be effective until October, 2001. Conforming the premium structure to S-CHIP will enable the State to coordinate any future child health assistance expansions with MinnesotaCare. The net cost of this adjustment would be considered a special health initiative.

Adjustments to the MinnesotaCare sliding scale premium schedule will result in a loss of premium revenue, and increased costs due to a small increase in enrollment. The additional cost to the State for eliminating the premium for children in families with income below 150% of poverty, and capping the premium at 5% of family income will be considered a special health

initiative, will be matched at the S-CHIP rate, and count agains the S-CHIP allotment. We request 100% federal matching funds for the cost of eliminating premiums for American Indian children, since the federal government has a trust responsibility for Indian people, and this trust responsibility extends to the provision of health care. Since the loss of revenue, and increased expenditures related to increased enrollment due to premium changes cannot be attributable to individual enrollees, we propose that, for purposes of calculating the S-CHIP match, we use an agreed upon estimate of state costs.

In the period prior to October, 2001, the MinnesotaCare premium schedule would be maintained through waivers of Title XXI.

Coverage of Parents in MinnesotaCare. HCFA advised states by letter on July 31.2000 that HCFA would consider coverage of Darents under SCHIP with a section 1115 waiver proposal. States that expanded Medicaid coverage for Darents on or before March 31.2000 are limited to demonstration proposals for Darents with income above 100% of federal Doverty levels.

The MinnesotaCare Program income level expanded in January 1. 1993 to 275% of federal poverty levels for families with children. Minnesota began receiving federal financial participation (FFP) for children and pregnant women up to age 21 on July 1. 1995. We have been receiving FFP for oarents and relative caretakers with income at or below 175% of the federal poverty levels as of March 1. 1999. We will begin clairning regular FFP for MinnesotaCare Darents with income above 175% on January 1. 2001.

This reauest seeks SCHIP enhanced match for MinnesotaCare parents and relative caretakers {hereafterreferred to as parents) of children under age 19. The request for S-CHIP match for these individuals will be limited to those who have income above 100% and at or below 275% of the federal poverty levels. We propose to begin claiming the S CHIP match for these MinnesotaCare Darents effective Januarv 1.2001. We propose to continue to apply the MinnesotaCare eligibility criteria. benefit packages and cost-sharing arrangements already approved for these Darents under the MinnesotaCare Health Care Reform waiver. The following is a summary of the conditions of enrollment for Darents.

MinnesotaCare Darents are determined eligible under a moss income test, and must not have had access to other health insurance for four months. nor currently have access to employer-sponsored coverage. the cost of which the employer subsidizes at 50% or more. MinnesotaCare Darents receive most of the Medicaid benefit set, but there are exclusion. For more detail. please refer to the MinnesotaCare protocol attached as Appendix 1. In addition. MinnesotaCare parents with income between 175% and 275% of Doverty have an annual $10.000 cap on inpatient hospital benefits.

All Darents in MinnesotaCare have premium and copavment requirements. The sliding fee scale for Darents with income between 100 and 275% of Doverty begins at 2.3 % and graduates to 8.8% of family income. Parents have copavments of $3 Der prescription and $25 for eveglasses: and

parents with income between 100% and 175% have a copayment of 50% on all nonpreventive dental services.

Minnesota meets the criteria necessary to request coverage of parents under SCHIP, according to HCFA's waiver guidance outlined in its letter dated July 31, 2000:

- Minnesota has long covered children above 200% of federal poverty levels on a statewide basis under the MinnesotaCare Program, without enrollment restrictions.

- Minnesota's application and redetermination process promotes enrollment and retention of eligible children. Applicants for MinnesotaCare have always been able to mail in their applications and renewal forms; applicants for the MA Program have been able to mail in their applications and renewals since the latter part of 1996. In February, 2000 the application forms used in both programs were significantly shortened. Children have no asset test in MA or MinnesotaCare.

There are a number of other policies in the MinnesotaCare Program that promote retention of children and families. The MinnesotaCare Program does not require verification of eligibility factors at initial application or at renewal. Families found eligible on the face of the application are notified of eligibility and given another 30 days to submit necessary verification. The Minnesota Health Care Reform Waiver allows the State to use a 12-month renewal period for all families in the MinnesotaCare Program. This means that no changes in financial circumstances are considered until the annual renewal date. However, families with reduced income may report this change for the purpose of lowering the MinnesotaCare premium amount.

Allowing the State to cover MinnesotaCare Parents under S-CHIP will help the state continue to assure coverage for this children and their Parents, and to continue to make improvements in the program so that we can further reduce the rate of uninsured children. MinnesotaCare enrollment of families with children has seen a small but steady increase each year. Health care costs for parents are higher than for children and are expected to increase. Recent studies have demonstrated that access of Parents to health coverage improves health care participation of children.[4]

Other Special Health Initiatives. We propose to use unspent Title XXI funds to:

- Target child health needs through existing state and local projects that meet Public Health Improvement Goals. The State will contribute to, or fund special health initiatives for children and adolescents in the areas of mental health and oral health.

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[4] Ku, L and Broaddus, M., "The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms", Center on Budget and Policy Priorities, September, 2000; Hansen, Karla L., Ph.D., "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care **Use** Revisited", ***Inquiry,*** Fall, 1998, Vol. 35, 294-302.

- Develop new special health initiatives that meet other Public Health Improvement Goals for children and adolescents, including but not limited to, reducing lead poisoning among children, assuring access to quality health services for children in racial and ethnic minority groups, eliminating disparities in health outcomes for children and adolescents in racial and ethnic minority groups; and promoting health for all children and adolescents.

Minnesota proposes to use its unspent Title XXI allotments to fund special health initiatives for children and adolescents in need. These initiatives are selected because they meet one or more of the State's Public Health Improvement Goals 2004 for children and adolescents.

The "Minnesota Public Health Improvement Goals 2004" (Appendix **3)** is an initiative of the Minnesota Department of Health to improve health statewide and to demonstrate that prevention and health promotion can hold down health care costs and improve qualify of life.

A statewide planning process was used to develop the 18 Public Health Improvement Goals. Assessments of health problems and identification of priorities were conducted by the States's 49 Community Health Boards and submitted to the leadership committee, the Minnesota Health Improvement Partnership, for development of the goals. Representation on the leadership committee came from **26** statewide organizations. The committee established 18 goals for Public Health improvement, many of which specifically involve health care needs of children. Having been established through a public planning process, these goals offer a valuable framework for establishing and developing special health initiatives for children and adolescents.

There are a number of projects currently being conducted in the State or identified as critical health initiatives which the State would adopt as special health initiatives. These initiatives are in the areas of mental health and dental health. Matching federal funds under Title XXI would allow the State to expand the available funding for these initiatives, and fund the nonfederal share of new special health initiatives. This process would involve ongoing stakeholder participation. Potential initiatives for development include reduction of blood lead poisoning, expansion of mental health services for children and adolescents, and eliminating health coverage disparities for populations of color.

1. **Mental Health Special Health Initiatives.** Minnesota seeks to enhance the State's ability to assure access to, and provide mental health services by targeting particularly vulnerable children and adolescents in three initiatives. They support the Public Health Improvement Goal to promote, protect and improve mental health of children and adolescents.

   A. Mental Health Screening for Children in the Juvenile Court System. The Children's Mental Health Division of the Department of Human Services conducts a grant program for the purposes of funding mental health screening, assessment and treatment of children who are in the juvenile court system, or at risk of entering the system. These are a group of children for whom assessments are needed but often missed. The target group includes both

children found to be in need of protection or services, and children found to be delinquent. The project seeks to reduce recidivism, improve school performance and maintain family stability by identification and treatment of underlying emotional problems contributing to "at risk" behaviors.

Qualified mental health professionals perform the assessments. Evaluation data show that approximately 23% of the children screened are referred for treatment services.

State funding for this project is approximately $1 million per calendar year. This amount funds projects in only 15 of the State's 87 counties.

Matching the State investment with Title XXI funds would enable the State to expand the available funding and would give other counties the opportunity to develop this effort. The grant requests each year are triple the amount of state funding available. **A** Request for Proposals would be issued to receive new grant requests.

B. Health Care Outreach and Services for Homeless Children and Adolescents. A second vulnerable population is children and adolescents who are homeless. Surveys show that on a given night as many as 500 young people 17 years or younger are without shelter. During the course of a year, nearly 10,000 youths have at least one episode of homelessness. These groups may experience homelessness with their families, or without them.

The Children's Mental Health Division of the Department of Human Services awards grants to provide for mental health screening and referral services for homeless children and unaccompanied homeless youth. Service contacts are made in shelter, transitional housing programs and drop-in centers. Currently about 1,000 adolescents are served under eight grant projects funded with $750,000 in state funds. Title XXI funds would enable the State to better serve this group of children and adolescents, either expanding access through additional grantees, or enhancing the capabilities of existing grantees.

C. Access to Mental Health Services for Children Without Coverage. Each year many family members and social workers seek assistance from county agencies to provide needed mental health services to many hundreds of children and adolescents. And each year counties fund mental health services for which no other payment source exists. These groups are not those who qualify for public health care programs, because those who qualify will be directed to those programs. These are children with serious and emotional disturbances whose needs cannot be met without public assistance. The families of these children may have health insurance that does not cover the needed service, or the family may be uninsured.

Minnesota currently makes available $19 million in grants each year to counties and local children's mental health collaboratives for the provision of community-based mental

health services for children with emotional disturbance and their families. Approximately half that amount is used for mental health services not covered by Medical Assistance or MinnesotaCare, and the other half provides mental health services for children without Medical Assistance eligibility or other health coverage.

The services include both outpatient and home-based clinical and rehabilitative services. The continuum of services available is based on the Child and Adolescent Service System Program (CASSP) model advocated by the federal Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Services supported by these grant funds include:

- Education and prevention services
- Outreach
- Mental health early identification and intervention services
- Emergency and crisis intervention services
- Outpatient services
- Family community support services
- Day treatment services
- Screening for residential and inpatient care
- Case management services
- Therapeutic supports of children in foster care
- Professional home-based family treatment

These grant funds, along with other county funds, support the provision of these services to persons without third party coverage for the services -- either because they are not insured, or the insurance coverage they carry does not completely cover mental health treatment and rehabilitative services. Where third party coverage does exist, it must be used prior to using these grant funds.

A conservative application of the prevalence estimate methodology published by CMHS estimates that there are over 71,000 children in Minnesota with a severe emotional disturbance. Of that amount, roughly 45% or 32,289 rely on the public sector for services. Even so, publically funded services reached 19,114 children in CY 1997, a little more than half the estimated public sector need.

With additional funding, Minnesota counties could be more aggressive in outreach activities and provide more intensive level of clinical and supportive mental health services to a larger number of emotionally disturbed children and their families. Proposed service enhancements and special initiatives include:

- Expansion of the availability of day treatment services. These school-based

services are very effective in helping SED children in achieving improved functioning and skills appropriate to their developmental level. Unfortunately, within any community, the services are only available in some grade levels or schools.

- Improved availability of culturally competent services. Minnesota is becoming increasingly diverse in its population and this has important implications for the provision of children's mental health services. One's culture forms the basis on one's identity and perception, and both are key to a child's treatment and rehabilitation. Funds here could support efforts for provider development, including recruitment and retention of staff from minority cultures as well as approaches to intervention that are culturally specific.

- Improved crisis services. Because the need for public coverage of mental health services for children is so great, the public service system has difficulty planning for and effectively dealing with crisis situations as they occur. Many communities cite a need for mobile, community-based crisis intervention and stabilization services.

- Expanded early identification and intervention services. Much of the current public resources are devoted to a small portion of high need children and their families. If more effort was placed in tertiary prevention approaches, many of these children could avoid prolonged, intensive treatment later in their lives.

2. **Access to Dental Care.** The lack of oral health services for low-income children and their families is recognized as a public health crisis throughout the country. Minnesota has reported increased difficulty in children obtaining access to dental care. The Surgeon General is expected to recognize access to oral health as a priority health goal within the next few months.[5] Minnesota's Public Health Improvement Goals already do so. The objectives seek to increase the number of children with protective sealants and to increase to 75%, by 2004, the proportion of children with protective sealants on all chewing surfaces. Among a number of strategies designed to increase access to dental services, the State Legislature appropriated funds to the Minnesota Department of Human Services to assist community dental clinics in maintaining or improving their ability to serve patients.

The Health Care Administration of the Department of Human Services proves grants to help community dental projects defray equipment and start-up costs. Awards were made in August, 1999 to eight grantees from a total of $600,000 in State funds for state fiscal year 2000. Of the people whom the grantees plan to serve through their projects, approximately two-thirds are children. To assure that the funds would improve access for clients, the grant awards were made on the basis of direct increase in ability to serve new patients. Two of the grants funded community clinics for children.

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[5] State of the State Report, January 2000, The Alpha Center.

Minnesota seeks Title XXI funds to help expand these efforts. The increase in available funding would help fund a number of the proposals with merit which remain unfunded.

3. **Development of Other Special Health Initiatives.** Minnesota seeks authority to develop other proposals that meet Minnesota Public Health Improvement Goals for Children and Adolescents. Other relevant goals for children and adolescents are as follows:

1. Eliminate disparities in health outcomes and the health profile of child and adolescent populations of racial and ethnic minorities

- **Promote health for all children and adolescents.**

- **Assure access to and improve the quality of health services for children and adolescents.**

Following are potential projects that could be funded as special health initiatives.

A. Reduce Blood Lead Poisoning Hazards. This proposal supports the Public Health Improvement Goal to reduce exposure to environmental health hazards, specifically childhood lead poisoning.

Lead poisoning has been identified by the U.S. Centers for Disease Control and Prevention (CDC) as the most common pediatric environmental health problem in young children. Its effects are often not identified until long after exposure. Studies have established that lead levels as low as 10 micrograms per deciliter of blood can damage a child's developing nervous system; and that blood lead levels of 70 micrograms per deciliter can cause very serious health consequences that include seizures, coma and death. A pregnant woman's exposure to lead can harm the developing brain and nervous system of the fetus.

Of homes built before 1978, 75% are estimated to contain some lead-based paint. Paints used before 1950 commonly contained up to 50% lead. Other sources of exposure for children include soil, drinking water and living with an adult exposed through work or a hobby.

There is currently no state law requiring blood lead screening in children. However, it is required and conducted in Minnesota through the EPSDT Program. Of the children screened in 1996, approximately 10 percent were found with blood levels at or above 10 micrograms per deciliter. Children in Minnesota public health care programs have a funding source for blood lead screening. Uninsured children need to be screened. The goal of a special health initiative for blood lead screening is to detect and control blood lead levels at the early stages.

The Minnesota Department of Health published guidelines for a targeted childhood lead screening for use statewide in Minnesota. The guidelines are based upon the CDC's recommendations to state and local public health authorities. Targeted screening is designed to take into account the various risk factors for lead poisoning, which may vary by geographic region.

(i) **Initiative for Blood Lead Screening.** To assure that all children and pregnant woman who require screening for blood lead levels receive them, a fund is needed to serve those uninsured children from ages **6** months to 72 months and uninsured pregnant women. All screening would be conducted in accordance with the Minnesota Department of Health's guidelines for targeted childhood lead poi soning screening.

(ii) **Initiative for Lead Hazard Reduction.** The effects of childhood lead poisoning cannot be reduced or eliminated without accompanying lead hazard reduction efforts. Local public health programs need funding to engage in the necessary work. This effon would be administered by the Minnesota Department of Health accomplished through a grant program for lead hazardous reduction work in child-occupied facilities (homes, child care facilities, schools, and playgroimds).

B. **Preventive Dental Services.** The Surgeon General is expected to recognize access to oral health as a priority health goal within the next few months.[6] Minnesota's Public Health Improvement Goals already do so. The objectives seek to increase the number of children with protective sealants and to increase to 75%, by 2004, the proportion of children with protective sealants on all chewing surfaces.

Dental sealants have been found to be highly effective in protecting permanent teeth of young children from decay, and also in preventing the advance of oral health disease in children. It is even recommended in cases of oral disease of primary teeth in very young children. Protective dental sealants are extremely cost-effective. Currently the cost per child (at the Medicaid rate) for sealants on all four molars is $104. Fluoride treatments at an additional cost of $14 would also be a cost-effective addition to preventive services.

Providing these services on a broader scale at community locations would enable children who are uninsured or not covered for such services to have access to oral health. The State would make grants available to community clinics and other non-profit community organizations, public health entities, professional associations, health care plan or other organizations demonstrating the ability to provide dental services to low-income children

[6] State of the State Report, January 2000, The Alpha Center.

uninsured for dental services.

4. **Other Potential Special Health Initiatives.** The Minnesota Health Improvement Goals for children and adolescents would be supported by any of the following proposals:

- Establish a grant program for tribes and urban Indian health programs to improve health care services and health care access for American Indian children, focusing on services for children not funded by the Indian Health Service.

- Establish a grant program to increase funding for migrant health care programs that provide direct services to migrant workers and their families.

- Address the specific needs of Minnesotans with limited English language proficiency through targeted outreach and health care access activities. Fund health care-related recommendations in DHS's Limited English Language Proficiency Plan.

- Extend funding for the DHS health care access project. Funding for this project ends with the current biennium. In addition, expand the role of the health care access project:

- Fund DHS health care access efforts at DHS regional sites. Establish links between Minnesota Health Care programs and other public programs such as WIC, Headstart, and public schools and public school lunch programs.

- Fund vision care for children who are uninsured or underinsured.

- Fund school nurse positions needed to assure an on-site nurse at every school with 60% or more student population eligible for the school lunch program.

- Establish a fund for uninsured children to meet health care needs related to certain diseases, such as those related to diabetes, asthma, iron deficiency anemia.

- Include uninsured population figures in setting FQHC Medicaid rates; or establish a grant program to cover uncompensated care costs.

- Use direct payments to provide health services to uninsured children not eligible for Minnesota Health Care Programs (need to check with MDH for any existing state funds for this purpose).

- Establish a grant program to make transportation available to low-income families in rural areas needing health care services.

- Fund the immunization registry for non-MA eligible children.